IDAHO DEPARTMENT OF
HEALTH & WELFARE

C. L. "BUTCH" OTTER, GOVERNOR
RICHARD M. ARMSTRONG, DIRECTOR

DEBBY RANSOM, R.N., R.H.I.T – Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0036
PHONE: (208) 334-6626
FAX: (208) 364-1888
E-mail: fsb@idhw.state.id.us

September 17, 2008

Russell McCoy
Rulon House
415 South Arthur
Pocatello, Idaho 83204

RE: Rulon House, Provider #13G020

Dear Mr. McCoy:

This is to advise you of the findings of the Medicaid/Licensure survey of Rulon House, which was conducted on September 11, 2008.

Enclosed is a Statement of Deficiencies/Plan of Correction Form CMS-2567, listing Medicaid deficiencies and a similar form listing State licensure deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction. **It is important that your Plan of Correction address each deficiency in the following manner:**

1. What corrective action(s) will be accomplished for those individuals found to have been affected by the deficient practice;

2. How you will identify other individuals having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;

3. What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur;

4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and,

5. Include dates when corrective action will be completed. 42 CFR 488.28 states ordinarily a provider is expected to take the steps needed to achieve compliance within 60 days of being notified of the deficiencies. Please keep this in mind when preparing your plan of correction. For corrective actions which require construction, competitive bidding, or other issues beyond the control of the facility, additional time may be granted.

Sign and date the form(s) in the space provided at the bottom of the first page.

After you have completed your Plan of Correction, return the original to this office by **September 30, 2008,** and keep a copy for your records.

You have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2007-02. Informational Letter #2007-02 can also be found on the Internet at:

http://www.healthandwelfare.idaho.gov/site/3633/default.aspx

This request must be received by September 30, 2008. If a request for informal dispute resolution is received after September 30, 2008, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during our visit. If you have questions, please call this office at (208) 334-6626.

Sincerely,

MICHAEL A. CASE
Health Facility Surveyor
Non-Long Term Care

NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

MC/mlw

Enclosures

DEVELOPMENTAL OPTIONS
PROMOTING FUNCTIONAL INDEPENDENCE THROUGH PERSON-CENTERED SERVICES

September 26, 2008

Ms. Nicole Wisenor, Supervisor
Non-Long Term Care
Department of Health and Welfare
Division of Medicaid
Bureau of Facility Standards
P. O. Box 83720
Boise, ID 83720-0036

Dear Ms. Wisenor:

Please find enclosed the completed *STATEMENT OF DEFICIENCIES / PLAN OF CORRECTION* for Rulon House Group Home from the survey completed September 11, 2008. On the Statement of Deficiencies / Plan of Correction, Form HCFA-2567, I have listed the necessary corrective actions.

I hope you find the Statement of Deficiencies / Plan of Correction acceptable. If there is any additional information you require or if you have any questions, please contact me at the address listed below.

Sincerely,

Russell C. McCoy, M.A. Ed.
Executive Director

Enclosures

Russell C. McCoy, Executive Director • rmccoy@ida.net
415 South Arthur • Pocatello, Idaho 83204 • Phone (208) 233-6833 • Fax (208) 233-6842 • doptions@ida.net • www.developmentaloptions.com

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G020	A. BUILDING _____ B. WING _____	09/11/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RULON HOUSE	2369 RULON POCATELLO, ID 83201

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS The following deficiencies were cited during your annual recertification survey. The survey was conducted by: Michael Case, LSW, QMRP, Team Leader Common abbreviations/symbols used in this report are: ADHD - Attention Deficit Hyperactivity Disorder ATS - Active Treatment Specialist BMP - Behavior Management Program HRC - Human Rights Committee IPP - Individual Program Plan OCD - Obsessive Compulsive Disorder PICA - Ingestion of Non-Edible Items PTSD - Post Traumatic Stress Disorder QMRP - Qualified Mental Retardation Program SIB - Self Injurious Behavior	W 000	RECEIVED OCT 02 2008 FACILITY STANDARDS	
W 120	483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES The facility must assure that outside services meet the needs of each client. This STANDARD is not met as evidenced by: Based on observation, record review, and staff interview it was determined the facility failed to ensure outside services met the needs for 1 of 1 individuals (Individual #4) who attended a public school. This resulted in outside services not being sufficiently coordinated. The findings include: 1. Individual #4's 4/2/08 IPP stated she was a 20 year old female whose diagnoses included microcephaly, autism, and profound mental	W 120	**W120 483.410(d)(3)** The Qualified Mental Retardation Professional will meet with Individual #4's school teacher before October 15, 2008 and provide the teacher with updated pertinent information that will assist with her school day. To ensure this deficiency does not occur again, the Qualified Mental Retardation Professional will meet with any individual's school teachers prior to a new school year and provide him/her with the current behavior management program, individual program plan and programs. The Qualified Mental Retardation Professional will also provide the school with updates throughout the school year.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Executive Director	09/26/08

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G020	A. BUILDING _____ B. WING _____	09/11/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RULON HOUSE	2369 RULON POCATELLO, ID 83201

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 120	Continued From page 1 retardation. She attended a public school program Monday through Friday. An observation was conducted at Individual #4's school on 9/9/08 from 10:45 - 11:35 a.m. During that time, Individual #4's teacher was interviewed. When asked, the teacher stated the school had not been provided with Individual #4's programs for activities of daily living or interventions for her maladaptive behaviors. The teacher stated the school could not implement training the same way the facility did without having Individual #4's programs. The teacher stated Individual #4 exhibited self injurious behavior that included hitting herself in the head. The teacher stated no information had been provided by the facility regarding interventions for Individual #4's self injurious behavior. Individual #4's school record was reviewed and contained a blank form, titled "Food And Texture Tolerance," from the facility. No additional information from the facility was present in Individual #4's school record. Training programs in place for Individual #4 at the facility included communication skills, toileting, hand washing, decrease screaming and yelling, and decrease SIB, including head slapping or scratching. These programs were not present at Individual #4's school. When asked if facility staff visited Individual #4 at school, the teacher stated the facility's ATS had visited the school once during the current school year, but had not provided the school with information regarding Individual #4. The teacher	W 120	Corrective Action Completion Date: October 27, 2008 Person Responsible: Ryan Shelton, Qualified Mental Retardation Professional	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G020	A. BUILDING _____ B. WING _____	09/11/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RULON HOUSE	2369 RULON POCATELLO, ID 83201

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 120	Continued From page 2 stated the facility's ATS stood and watched Individual #4 for a period of time, then left. The teacher stated no other visits to the school had been made by the facility during the current school year. When asked during an interview on 9/9/08 at 11:45 a.m., the ATS stated she had been to the school once to observe the school's interaction with Individual #4. The ATS stated verbal information may have been provided to the school, but no programs, data sheets, or other documentation had been provided because Individual #4's teacher was present for Individual #4's IPP meeting. The ATS stated the school should have been aware of Individual #4's programs. When asked during an interview on 9/11/08 from 9:05 - 10:35 a.m., the QMRP stated he had provided written information to the school during the previous school year, but had not provided any information for the current school year. The QMRP stated he had not been to the school during the current school year. The facility failed to ensure Individual #4's school program was provided with sufficient information.	W 120		
W 124	483.420(a)(2) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore the facility must inform each client, parent (if the client is a minor), or legal guardian, of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment.	W 124	**W124 483.420(a)(2)** Individual #1's Consent to Treat will be revised to incorporate the use of one-on-one staffing and room checks to remove items used for SIB or PICA. The Qualified Mental Retardation Professional will review all resident files and provide the Residential Program Director with all restrictive elements needing approval on an annual basis. If restrictive changes	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G020	A. BUILDING _____ B. WING _____	09/11/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RULON HOUSE	2369 RULON POCATELLO, ID 83201

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 124	Continued From page 3 This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure sufficient information was provided to parents/guardians on which to base consent decisions for 1 of 4 individuals (Individual #1) whose written informed consents were reviewed. This resulted in insufficient information being provided to an individual's guardian regarding restrictive interventions. The findings include: 1. Individual #1's 8/28/07 IPP stated he was a 49 year old male whose diagnoses included severe mental retardation. Individual #1's BMP, revised 4/22/08, stated "Staff must have [Individual #1] within eye sight at all times. [Individual #1's] assigned staff is to be with him (in the same room) at all times." The program also stated staff were to check Individual #1's bedroom weekly to remove items that may be used for SIB or PICA. During observations on 9/8/08 from 3:20 - 4:05 p.m. and 5:25 - 6:30 p.m., and on 9/9/08 from 6:50 - 8:15 a.m. and 11:40 a.m. - 12:25 p.m., Individual #1 was observed to have staff assigned to work only with him. The staff working with Individual #1 remained with him at all times in all areas of the facility. Individual #1's Consent to Treat, dated 1/20/08, did not include the use of one-to-one staffing or room checks to remove items used for SIB or PICA. When asked during an interview with the QMRP and Program Director, on 9/11/08 from 9:05 -	W 124	are being considered in between annual guardian consent approvals, the Qualified Mental Retardation Professional will submit a request to obtain guardian approval prior to the restrictive being implemented. This request will also be submitted to the Residential Program Director. Corrective Action Completion Date: November 5, 2008 Person Responsible: Jamie L. Anthony, Residential Program Director and Ryan Shelton, Qualified Mental Retardation Professional	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G020	A. BUILDING _____ B. WING _____	09/11/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RULON HOUSE	2369 RULON POCATELLO, ID 83201

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 124	Continued From page 4 10:35 a.m., both stated Individual #1's one-on-one staff was present due to his behavior of elopement, SIB, and PICA. Both the QMRP and the Program Director stated the use of one-to-one staffing and room checks to remove items used for SIB or PICA had not been included in the Consent to Treat. The facility failed to ensure sufficient information was provided to individuals' guardians regarding restrictive interventions.	W 124		
W 125	483.420(a)(3) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure individuals' needs for guardianship were addressed for 3 of 4 individuals (Individuals #1 - #3) whose IPPs were reviewed. Failure to obtain guardianship did not ensure individuals' rights were protected. The findings include: 1. Individual #1's 8/28/07 IPP stated he was a 49 year old male whose diagnoses included severe mental retardation. His IPP stated he was his own guardian. Under the section titled "Understanding of Rights," the IPP stated Individual #1 "has a very limited understanding of his rights and the rights of others. He does not know what is meant by a 'right' and does not	W 125	**W125 483.420(a)(3)** For Individuals #1-3 the facility will actively pursue guardianship on a quarterly basis with any identified family or friends of the individual. The facility will identify any other clients who may be affected by this deficiency and implement the same corrective action as listed above. A form will be created by the Residential Program Director that will track the facility's efforts in obtaining guardianship. Corrective Action Completion Date: November 5, 2008 Person Responsible: Jamie L. Anthony, Residential Program Director and Ryan Shelton, Qualified Mental Retardation Professional	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G020	A. BUILDING _____ B. WING _____	09/11/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RULON HOUSE	2369 RULON POCATELLO, ID 83201

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 125	Continued From page 5 understand that he has rights." Individual #1's Human Rights Committee approval, dated 6/19/08, stated he had restrictive interventions which included door alarms on the facility doors and his bedroom door due to elopement, physical restraint up to a one arm standing restraint, physical checking of his shoes, braces and clothing for items related to PICA, and the use of Zoloft (an antidepressant drug) and Risperdal (an antipsychotic drug). Individual #1's Behavior Management Program, revised 4/22/08, also included a one-to-one staff and room searches due to behaviors of elopement, SIB, and PICA. Individual #1's record contained a letter to a family member, undated, requesting they become Individual #1's guardian. When asked during an interview on 9/11/08 from 9:05 - 10:35 a.m., the Program Director stated a yearly request had been made of the family to become Individual #1's guardian, but no additional efforts had been made. At 1:30 p.m., the Program Director provided a form, titled "Resident Sheet - Obtaining Guardian," which documented a letter had been sent to Individual #1's family members on 5/22/07 and 8/9/08. No additional efforts were documented. 2. Individual #2's 10/3/07 IPP stated he was a 38 year old male whose diagnoses included PTSD and profound mental retardation. His IPP stated he was his own guardian. Under the section titled "Understanding of Rights," the IPP stated Individual #2 "has a very limited understanding of his rights."	W 125		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G020	A. BUILDING _____ B. WING _____	09/11/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RULON HOUSE	2369 RULON POCATELLO, ID 83201

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 125	Continued From page 6 Individual #2's Human Rights Committee approval, dated 3/27/08, stated his restrictive interventions included a wake up schedule where he was toileted at 1:00 a.m. and the use of Celexa (an antidepressant drug). Individual #2's record contained an e-mail, dated 12/18/06, to Individual #2's parents asking if they were interested in becoming his guardian. Individual #2's parents responded that they were not interested "at this time." When asked during an interview on 9/11/08 from 9:05 - 10:35 a.m., the QMRP stated Individual #2's parents were asked about guardianship at his yearly staff meeting. At 1:30 p.m., the Program Director provided a form, titled "Resident Sheet - Obtaining Guardian," which documented a letter had been sent to Individual #2's family members on 5/22/07 and 8/9/08. No additional efforts were documented. 3. Individual #3's 2/12/08 IPP stated he was a 42 year old male whose diagnoses included seizure disorder, OCD, ADHD, and moderate mental retardation. His IPP stated he was his own guardian. Under the section titled "Understanding of Rights," the IPP stated Individual #3 "does not appear to possess any understanding with regards to his rights and what is meant by a 'right' as explained to him. He does not appear to understand that he is allowed to know what his rights are, what services are provided for him, and what house rules are." Individual #3's Human Rights Committee approval, dated 6/19/08, stated his restrictive interventions included the use of Zyprexa (an	W 125		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G020	A. BUILDING _____ B. WING _____	09/11/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RULON HOUSE	2369 RULON POCATELLO, ID 83201

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 125	Continued From page 7 antipsychotic drug) and Thorazine (an antipsychotic drug). When asked during an interview on 9/11/08 from 9:05 - 10:35 a.m., the Program Director stated a yearly request had been made of the family to become Individual #3's guardian, but no additional efforts had been made. At 1:30 p.m., the Program Director provided a form, titled "Resident Sheet - Obtaining Guardian," which documented a letter had been sent to Individual #3's family members on 5/22/07 and 8/9/08. No additional efforts were documented. The facility failed to ensure guardianship was being actively pursued for Individuals #1, #2, and #3.	W 125		
W 276	483.450(b)(1)(i) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR Policies and procedures that govern the management of inappropriate client behavior must specify all facility approved interventions to manage inappropriate client behavior. This STANDARD is not met as evidenced by: Based on observation, review of the facility policy and procedures, record review, and staff interview, it was determined the facility failed to ensure the policy addressing maladaptive behaviors included all positive and intrusive behavior interventions approved for use in the facility for 1 of 4 individuals (Individual #1) whose records were reviewed. This resulted in interventions being used without the necessary facility approvals. Findings include: 1. Individual #1's 8/28/07 IPP stated he was a 49	W 276	**W276 483.450(b)(1)(i)** The facility's behavioral intervention policy will be updated to include the missing components of one-on-one staffing, personal checks to remove items from an individual, and room checks to remove items from an individual. The assigned Qualified Mental Retardation Professional will be required to complete a newly created form each time Behavior Management Programs are revised or updated that will require him/her to ensure that behavioral interventions are in fact in the facility's behavioral intervention policy. Corrective Action Completion Date: November 15, 2008 Person Responsible: Jamie L. Anthony, Residential Program Director and Ryan	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G020	A. BUILDING _____ B. WING _____	09/11/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RULON HOUSE	2369 RULON POCATELLO, ID 83201

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 276	Continued From page 8 year old male whose diagnoses included severe mental retardation. Individual #1's BMP, revised 4/22/08, stated "Staff must have [Individual #1] within eye sight at all times. [Individual #1's] assigned staff is to be with him (in the same room) at all times." The program also stated staff were to check Individual #1 three times a day for items he may use for SIB or PICA and ask him to surrender those items. Additionally, staff were instructed to check Individual #1's bedroom weekly to remove items that may be used for SIB or PICA. During observations on 9/8/08 from 3:20 - 4:05 p.m. and 5:25 - 6:30 p.m., and on 9/9/08 from 6:50 - 8:15 a.m. and 11:40 a.m. - 12:25 p.m., Individual #1 was observed to have staff assigned to work only with him. The staff working with Individual #1 remained with him at all times in all areas of the facility. When asked during an interview with the QMRP and Program Director, on 9/11/08 from 9:05 - 10:35 a.m., both stated Individual #1's one-on-one staff was present due to his behavior of elopement, SIB, and PICA. Both the QMRP and Program Director stated the staff assigned to work with Individual #1 were to be within line of sight of him at all time and remain in the same room as Individual #1. Both the QMRP and Program Director stated staff were to be close enough to intervene if Individual #1 tried to elope or obtain items used for SIB or PICA. The facility's Behavioral Interventions policy, undated, listed five levels of interventions in the order of least restrictive to most restrictive. However, the policy did not include the use of	W 276	Shelton, Qualified Mental Retardation Professional	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G020	A. BUILDING _____ B. WING _____	09/11/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RULON HOUSE	2369 RULON POCATELLO, ID 83201

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 276	Continued From page 9 one-on-one staffing, personal checks to remove items from an individual, or room checks to remove items from an individual. When asked during an interview on 9/11/08 at 1:00 p.m., the Program Director stated one-on-one staffing, personal checks, and room checks were not included in the Behavioral Intervention policy. The facility failed to ensure all intrusive behavior interventions used in the facility were incorporated into the behavior policy.	W 276		
W 426	483.470(d)(3) CLIENT BATHROOMS The facility must, in areas of the facility where clients who have not been trained to regulate water temperature are exposed to hot water, ensure that the temperature of the water does not exceed 110 degrees Fahrenheit. This STANDARD is not met as evidenced by: Based on environmental review and staff interview, it was determined the facility failed to ensure hot water temperatures were maintained at or below 110 degrees Fahrenheit for 5 of 7 individuals (Individuals #1 - #5) who were unable to regulate water temperatures independently. This resulted in an increased risk of scald injuries during hand washing and bathing. The findings include: 1. Hot water temperatures were obtained at the facility during an environmental review on 9/9/08 from 3:50 - 4:45 p.m. and were recorded as follows: Upstairs hallway bathroom - 117.7 degrees	W 426	**W426 483.470(d)(3)** The water temperatures were corrected before the end of this survey. To ensure that the water temperatures remain within acceptable range, the Active Treatment Specialist will check these temperatures on a weekly basis and document this on the Weekly Home Inspection. Any discrepancies will be reported to the maintenance department so correction can be made. The grave yard staff also checks the water temperatures each morning (at approximately 5:00 am) and documents these numbers on the water temperature form. Corrective Action Completion Date: September 30, 2008 Person Responsible: Stella Leon, Active Treatment Specialist	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G020	A. BUILDING _____ B. WING _____	09/11/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RULON HOUSE	2369 RULON POCATELLO, ID 83201

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 426	Continued From page 10 Upstairs master bathroom - 117.5 degrees Downstairs bathroom - 118.0 degrees Laundry room sink - 117.9 degrees When asked if the individuals residing in the facility could regulate water temperatures, the ATS, who was present, stated Individuals #1 - #5 were not able to self regulate water temperatures. At that time, the ATS was notified of the water temperatures being too high. The facility failed to ensure water temperatures were maintained at or below 110 degrees Fahrenheit. Note: Water temperatures were re-checked on 9/10/08 at 11:30 a.m. and found to be within the acceptable range.	W 426		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G020	A. BUILDING _____ B. WING _____	09/11/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RULON HOUSE	2369 RULON POCATELLO, ID 83201

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
MM164	16.03.11.075.04 Development of Plan of Care To Participate in the Development of Plan of Care. The resident must have the opportunity to participate in his plan of care. Residents must be advised of alternative courses or care and treatment and their consequences when such alternatives are available. The resident's preference about alternatives must be elicited and considered in deciding on the plan of care. A resident may request, and must be entitled to, representation and assistance by any consenting person of his choice in the planning of his care and treatment. This Rule is not met as evidenced by: Refer to W124.	MM164	**MM164 16.03.11.075.04** Please refer to W124 RECEIVED OCT 02 2008 FACILITY STANDARDS	
MM167	16.03.11.075.07 Exercise of Rights Exercise of Rights. Each resident admitted to the facility must be encouraged and assisted, throughout his period of stay, to exercise his rights as a resident and as a citizen, and to this end can voice grievances and recommend changes in policies and services to facility staff and/or to outside representatives of his choice, free from restraint, interference, coercion, discrimination, or reprisal. This Rule is not met as evidenced by: Refer to W125.	MM167	**MM167 16.03.11.075.07** Please refer to W125	
MM271	16.03.11.100.04(b) Storage of Toxic Chemicals All toxic chemicals must be properly labeled and stored under lock and key. This Rule is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure all toxic	MM271	**MM271 16.03.11.100.04(b)** All toxic chemicals have been properly locked in the cabinet located in the garage of the facility. To ensure staff locks all toxic chemicals after each use,	

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G020	A. BUILDING _____ B. WING _____	09/11/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RULON HOUSE	**2369 RULON POCATELLO, ID 83201**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
MM271	Continued From page 1 chemicals were stored under lock and key for 7 of 7 individuals (Individuals #1 - #7) residing in the facility. The findings include: 1. An environmental review was conducted on 9/9/08 from 3:50 - 4:45 p.m. At that time, the following chemicals were found in an unlocked cabinet in the garage: - Two bottles of Lysol 4 in 1 cleaner. - A bottle of Lysol 4 in 1 antibacterial kitchen cleaner. - A can of Lysol disinfectant spray. - A bottle of Simplex glass cleaner. - A container of Arm and Hammer Pet Fresh carpet deodorizer. - A bottle of charcoal lighter fluid. - Two cans of spray paint. The ATS, who was present during the review, stated the items should have been locked. The ATS removed all items and placed them in a locked storage cabinet. The facility failed to ensure all toxic chemicals were stored in appropriate areas under lock and key.	MM271	training will be conducted once each quarter on this requirement. Training will be conducted in the staff meeting by the Active Treatment Specialist. Corrective Action Completion Date: November 15, 2008 Person Responsible: Stella Leon, Active Treatment Specialist	
MM380	16.03.11.120.03(a) Building and Equipment The building and all equipment must be in good repair. The walls and floors must be of such character as to permit frequent cleaning. Walls and ceilings in kitchens, bathrooms, and utility rooms must have smooth enameled or equally washable surfaces. The building must be kept clean and sanitary, and every reasonable precaution must be taken to prevent the entrance of insects and rodents. This Rule is not met as evidenced by: Based on observation, it was determined the	MM380	**MM380 16.03.11.120.03(a)** The 6 inch by 4 inch hole in the dining room is repaired, the 2 tiles on the hearth of the fireplace in the dining room have been repaired, the Lazy Susan has been cleaned, the deli drawer in the refrigerator has been replaced, the carpet in the living room, sitting room, and hallway is scheduled for cleaning on October 3, 2008, individual #1's nightstand has been	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G020	A. BUILDING _____ B. WING _____	09/11/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RULON HOUSE	2369 RULON POCATELLO, ID 83201

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
MM380	Continued From page 2 facility failed to ensure the facility was kept clean, sanitary, and in good repair for 7 of 7 individuals (Individuals #1 - #7) residing in the facility. The findings include: During an environmental survey conducted on 9/9/08 from 3:50 - 4:45 p.m., the following concerns were noted: - There was a 6 inch by 4 inch hole in the dining room wall to the left of the door leading to the garage. - There were two tiles on the hearth of the fireplace in the dining room that were cracked and broken. - The dining room carpet contained multiple dark stains, and was frayed at the seams by the sliding glass door. - The kitchen cabinet with the Lazy Susan contained food spills and a sticky substance. - The deli drawer in the refrigerator was broken and had sharp edges, and the lower vegetable drawer was cracked. - The carpet in the living room, sitting room, and hallway had multiple dark stains of various sizes. - Individual #1's nightstand was missing the top drawer and had exposed unfinished wood. - The carpet in the bedroom shared by Individual #1 and Individual #5 was stained. - The carpet in Individual #2's bedroom was stained.	MM380	replaced, the carpet in the bedroom shared by Individual #1 and Individual #5 is scheduled for cleaning on October 3, 2008, the drawer knobs on Individual #2's nightstand have been replaced, and both the sink in the downstairs bathroom and the sink in the laundry room are scheduled for replacement by November 14, 2008. Corrective Action Completion Date: November 14, 2008 Persons Responsible: Stella Leon, Active Treatment Specialist and Sam Guyette, Physical Facilities Manager.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G020	A. BUILDING _____ B. WING _____	09/11/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RULON HOUSE	2369 RULON POCATELLO, ID 83201

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
MM380	Continued From page 3 - The drawer knobs on Individual #2's nightstand were missing. - The sink in the downstairs bathroom was rusted around the overflow drain, and there were two sections of rusted metal which were sticking out from the sink. - The sink in the laundry room was rusted around the overflow drain.	MM380		
MM520	16.03.11.200.03(a) Establishing and Implementing polices The administrator will be responsible for establishing and implementing written policies and procedures for each service of the facility and the operation of its physical plant. He must see that these policies and procedures are adhered to and must make them available to authorized representatives of the Department. This Rule is not met as evidenced by: Refer to W276.	MM520	**MM520 16.03.11.200.03(a)** Please refer to W276	
MM859	16.03.11.270.08(f)(i) Supervision of Training and Habilitation Supervision of delivery of training and habilitation services integrating various aspects of the facility's program; and This Rule is not met as evidenced by: Refer to W120.	MM859	**MM859 16.03.11.270.08(f)(i)** Please refer to W120	